Evaluation report
March 2022

Medicaid Rate Setting

Office of Performance Evaluations
Idaho Legislature

Promoting confidence and accountability in state government

Office of Performance Evaluations

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Joint Legislative Oversight Committee 2021–2022

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From the director

March 16, 2022

Members
Joint Legislative Oversight Committee
Idaho Legislature

We have conducted four evaluations on Idaho's Medicaid program in the past decade. A common theme in all four evaluations has been the program's need for active, dynamic management. We consistently found problems with strategic planning and follow through, clear communication, meaningful performance measures, and stakeholder involvement.

The Division of Medicaid continues to have gaps in its management capacity. While the division is competent to establish a rate-review process, the process will likely not succeed because management has too many competing priorities. Division management has moved from crisis to crisis while neglecting critical but less urgent work. In this report, we make recommendations for the division and offer policy considerations for the Legislature to address gaps in the division's management capacity.

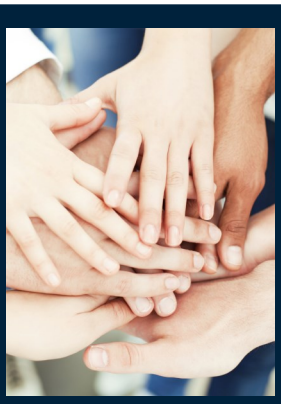
We thank the Department of Health and Welfare and the Division of Medicaid staff for their assistance and collaboration.

Sincerely,

Rakesh Mohan, Director
Office of Performance Evaluations

954 W. Jefferson Street
Suite 202
Boise, Idaho 83702
Ph. 208.332.1470
legislature.idaho.gov/ope/

Formal responses from the Governor and the Department of Health and Welfare are in the back of the report.



Ryan Langrill and Amanda Bartlett conducted this evaluation. Lauren Bailey copyedited the report.

Bob Thomas of Robert C. Thomas and Associates conducted the quality control review.

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Executive summary

Background, legislative interest, and study approach

Medicaid is a significant player in shaping Idaho's health care system. The Division of Medicaid, within the Department of Health and Welfare, spends billions on services for low-income people and families including children, pregnant women, the elderly, and people with disabilities. The program fulfills the role of a health insurance company and provides one of the largest single health plans in the state. The program also funds and oversees social support services that are generally not covered by private insurance or Medicare.

Provider payment rates are at the core of ensuring participants have access to quality care under the constraints of economy and efficiency. In March 2021, the Joint Legislative Oversight Committee directed us to evaluate the rate-setting process. The study requester wanted recommendations for how the division could implement a systematic plan for rate reviews and assist the Joint Finance-Appropriations Committee in budget setting.

Our report comprises findings in two categories: 1) the processes used by the division to set rates and 2) the division's stewardship and management capacity.

The division's process for systematically updating rates is effective in some areas and insufficient in others.

A large number of rates are regularly reviewed and updated. The division most commonly pays providers according to a published fee schedule that lists rates. Most rates on this fee schedule are linked to equivalent Medicare rates. Linked rates are regularly reviewed and updated.

Most Medicaid spending is tied to rates that do not have a sufficient review process. Benefits not covered by Medicare—long-term care, dental services, community supports for individuals with disabilities—are much less frequently adjusted. Rates for adult day health and home delivered meals, for example, are unchanged since 2006.

The rate-setting process for long-term services and social supports relies on cost surveys. Rate adjustments take a long time to implement and are prioritized by complaints and costs instead of well-operationalized measures. The division's measures primarily focus on problem avoidance rather than achieving the goals of Medicaid payment policy.

We recommend that the division incorporate six elements for rate setting. Examples of these elements include:

- a fee schedule that prioritizes and groups codes developed in conjunction with stakeholders
- an assessment of the payment method
- a structured and predictable timeline that prioritizes when rates will be adjusted and incorporates public and provider input

The division does not have a proactive monitoring system that would identify systemic issues. The broad goals of Medicaid payment policy are clear: to ensure that participants can access quality services economically and efficiently. The division uses cost as the primary system-level metric. The division does not have the information it needs to prioritize rates to review or to know whether rate adjustments have had their intended effect.

The division should operationalize its measures of access, quality, economy, and efficiency based on Idaho's priorities and embed these measures in the rate-setting process.

The division's rate reviews should be regular, public, and incorporate stakeholder input.

The division lacks management capacity to effectively implement a rate-review process.

Over the last decade, we have conducted three evaluations of the Division of Medicaid. We have consistently found problems with planning, management, and communication at the division and repeatedly made recommendations for improvement.

In this evaluation, we still saw patterns of rushed project planning, unclear expectations, and inconsistent follow through. In this case, we found that division staff had appropriate knowledge, skills, and ability to do the work, but staff were being asked to complete an unrealistic amount of work. This lack of capacity suggested that the division would not be able to successfully execute a systematic rate review.

We did not simply want to repeat the findings and recommendations made over the past decade. Doing so might lead to some short-term improvement but would ultimately leave policymakers disappointed in the outcome. We believe two things need to be addressed for the rate-review process to be successful and to address problems found in previous reports: management capacity and legislative collaboration.

The division should identify its key management needs and submit a budget request for the 2023 legislative session.

The Legislature should consider what it wants to control and what it wants to delegate to the division and invest accordingly. The Legislature could consider options such as additional reporting or the establishment of an oversight committee.

1 Why study Medicaid rate setting?

Background and legislative interest

Medicaid is a significant player in shaping Idaho's health care system and may be the most complex state-administered program. The program fulfills the role of a health insurance company and provides one of the largest single health plans in the state. The program also funds and oversees the quality of social support services that are generally not covered by private insurance such as developmental disability supports and nonemergency medical transportation.

Prior to the formal creation of Medicaid, Idaho provided medical assistance for elder care, the blind, maternity care, infants and dependent children.[1] Medicaid was created in 1965 to provide 'mainstream medical care' for these targeted populations.[2]

Provider payment rates are at the core of keeping Medicaid's costs and benefits balanced.

Since inception, lawmakers at the federal and state levels have wrestled with how to balance community health benefits of Medicaid with the cost to taxpayers. Provider payment rates are at the core of ensuring participants have access to quality care under the constraints of economy and efficiency.

When rates are too low, providers opt out of accepting Medicaid and leave participants with less access to care and lower-quality services. When rates are too high, program costs can escalate to the point of being unsustainable for states required to balance annual budgets.

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1. Joseph W. Mountin & Evelyn Flook, *Distribution of Health Services in the Structure of State Government: Chapter VIII—Maternity—child health activities by state agencies*, Public Health Rep., 57 (Nov. 27, 1942): 1794, 1798; Anne E. Geddes, *Programs of Public Assistance in the United States,* Monthly Labor Rev., 70(2) (Feb. 1950): 133; Selma Mushkin, *Medical Services and the Social Security Act Amendments of 1950*, Public Health Rep., (Jan. 26, 1951): 105-06.
2. *Medicare and Medicaid: Hearings Before the Committee on Finance*, 91st Cong. 57 (1970) (statement of John G. Veneman, Under Secretary, Department of Health, Education, and Welfare).

In the recent past, providers have approached legislators with two concerns about the Division of Medicaid. First, providers raised concerns about the infrequency of rate reviews. Second, when rate reviews were conducted, the division did not submit budget requests for adequate rate adjustments.

Medicaid is administered by the Division of Medicaid in the Department of Health and Welfare.

In March 2021, the Joint Legislative Oversight Committee directed us to evaluate the rate-setting process. The study requester wanted recommendations for how the division could implement a systematic plan for provider rate reviews that would assist the Joint Finance-Appropriations Committee in budget setting. The study request is in appendix A.

Study approach

We designed our study to evaluate the management process used by the Division of Medicaid to set provider payment rates and develop budget requests. The study scope is in appendix B. We conducted semi-structured interviews to develop a thorough description of the strengths and weaknesses of current processes. We interviewed division management and representatives of key provider and stakeholder associations including:

A detailed list of the documents we reviewed and the people we interviewed can be found in appendix C.

- Director of the Department of Health and Welfare
- Division of Medicaid management
- ACCSES-Idaho (formerly known as the Idaho Association of Community Rehabilitation Programs)
- Idaho Association of Community Providers
- Idaho Association of Home Care Providers
- Idaho Council on Developmental Disabilities
- Idaho Dental Association
- Idaho Health Care Association

We complemented our interviews with document reviews. From the document reviews, we learned about regulations and requirements, how the division makes decisions, communication within the division and with stakeholders, and how the division defines success. We reviewed the following types of documents:

- state and federal statutes, rules, and regulations
- division policy
- division budget development documents
- federally required reports

- division strategic plans and other management documents describing planning and implementation of Medicaid initiatives and rate-setting practices
- cost studies
- past evaluations and third-party assessments of Idaho Medicaid programs

We also reviewed evaluations, policy papers, and reports from MACPAC[3] and other states to learn about best practices that may be applied in Idaho.

Appendix C contains more information about our methods and evaluation approach.

This report begins with our findings about the rate-setting process in chapter 2 and proceeds in chapter 3 to deeper issues that need attention regarding the management and stewardship of the Medicaid program.

We took a big-picture approach when reporting our findings and recommendations. Sometimes, complexity and detail can obscure the fundamentals needed for good program implementation. Our recommendations are aimed at helping policymakers understand what the division needs to successfully implement the program in a way that incorporates Idaho specific values.

We acknowledge that Medicaid is a complex and difficult program to implement. Because the program is so large, it is often at the center of robust political debate. Medicaid administration is full of challenges that must be managed but can never be fully resolved. The division must be adaptable as there are changes in the economy, political environment, and leadership.

3. The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan, legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states. More information about the commission can be found at: https://www.macpac.gov/about-macpac/

Rate setting

2

Idaho's Division of Medicaid spends billions on services for participants every year. The program is funded through a combination of federal and state dollars. The federal match for Idaho's payments for services in 2022 was 70 percent.[4] Overall, the total Medicaid 2022 appropriation was 69 percent federal funds, 20 percent general funds, and 11 percent dedicated funds.

While federal dollars fund the majority of the spending, states have a large degree of discretion in designing the program and determining how providers will be paid for services. The division uses a variety of payment methods, including a published fee schedule, reimbursement based on provider costs, and population-based rates to managed care contractors. Exhibit 1 lists descriptions and examples of the different payment methods.

The division pays most providers using a published fee schedule. The schedule lists codes, representing a service, procedure, or equipment alongside the maximum price Medicaid will pay for each code. In fiscal year 2019 the division paid for 9,180 unique billing codes.

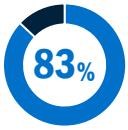
Rate setting, in this context, refers to the division's practices to determine the amounts listed on the published fee schedule. Most of the division's rate setting consists of updating the rates based on a Medicare equivalent code, covering about 8,150 of the 9,180 codes paid in fiscal year 2019. Rates for primary care are set at 100 percent of the Medicare rate while others are set at 90 percent. Linking Medicaid payment rates to equivalent Medicare rates ensures that most medical codes are regularly updated. Because linked codes have a process that ensures regular review and update, the rest of this chapter is focused on unlinked codes.

Medicaid is Idaho's largest government program.

$3.8 billion
FY 2022 total appropriation

380,000
covered individuals

9,180 Medicaid procedure codes used to pay providers.



Medicaid codes linked to Medicare

4. For more information on how matching rates are calculated visit https://www.macpac.gov/subtopic/matching-rates/. In quarters during which the public health emergency was active, the federal match was 77 percent.

Exhibit 1

Medicaid uses a variety of payment methods for different providers and services.

Method	Description	Examples
Fee schedule	Providers bill their usual and customary charge for service by billing code. Medicaid pays the amount billed or an established maximum rate from its published fee schedule.	Primary care, physician services, and personal care services
Cost based	Providers submit cost reports based on total costs incurred by participants. Medicaid pays based on allowable, provider-specific costs.	Long-term care per-diem rates, critical access hospitals
Classification based	Providers submit information to the division. Payment is based on the calculated intensity of the diagnosis or service provided, regardless of costs incurred.	Hospital services
Capitation	Medicaid pays a per-member, per-month rate to an intermediary that administers the benefit. Federal law requires the rate to be actuarially sound. The intermediary pays providers using cost-based or fee-schedule methods.	Idaho Behavioral Health Plan, dental services, Medicare-Medicaid coordinated plan, nonemergency medical transportation
Acquisition costs	Prescription drugs are paid for based on a published actual acquisition cost of the drug plus a dispensing fee for the pharmacy.	Prescription drugs
Premiums	Per-member, per-month rate paid as a premium for Medicare.	Medicare Premiums
Supplemental payments	Paid in addition to fees for service. Supplemental payments are tied to a provider characteristic or outcome. Hospitals receive payments based on serving a disproportionate share of uninsured patients, nursing homes based on quality measures.	Hospitals, long-term care facilities

Medicaid spending for codes not linked to Medicare

Medicare provides health benefits primarily to older adults, while Medicaid has a broader population and set of benefits. Therefore, not all Medicaid codes are covered by Medicare. Even though most codes are linked to Medicare, most spending was for codes not linked to Medicare. These unlinked codes can be divided into two broad categories: (1) traditional medical services not included on Medicare's published fee schedule, and (2) long-term services and social supports for seniors and supports for individuals with developmental disabilities not traditionally covered by health insurance.

Some traditional medical services not linked to Medicare do not have rules for rate adjustment.

The first category of unlinked codes comprises rates for traditional medical services. Statute requires that the method for rate setting should be set in administrative rule if not set in statute.[5] However, some codes billed by medical providers not linked to Medicare have no payment rate calculation method set in statue or rule. The rates for many of these codes were last changed before the statutory requirement was put in place.

Some rates for medical services not linked to Medicare have not changed in over a decade.

Medical providers were paid for hundreds of codes not linked to Medicare with no clear rate calculation. Medicaid paid $3.5 million in fiscal year 2019 for six codes related to pediatric enteral nutrition. The payment rates for three of the codes have not been updated in 11 or more years. The payment rates for these codes are lower than comparable rates in other states. Medicaid also paid $13 million for 21 codes for preventive visits. The payment rates for these codes were last updated in 2008 and are high compared to other states.

The division should promulgate rules to ensure rate setting for all codes complies with statute.

The division has two problems adjusting the rates for these codes. First, the division does not have the authority to adjust rates not covered by rule and is out of compliance with statute when it changes one of these rates. Second, these codes do not have a mandatory review schedule, and many have not been updated in more than 10 years.

We recommend that the division promulgate rules to cover these unlinked codes for traditional medical services. The rule can be general to cover codes in this category. The purpose of the rule would be to ensure that the codes are regularly reviewed and not overlooked. Additionally, the division should ensure rates with rules, such as dental services, are regularly reviewed.

5. Medicaid Cost Containment Act, IDAHO CODE §§ 56-260—266 (2021); restrictions on rate increases are found in IDAHO CODE §§ 56-261(4), 265(4).

In-depth cost surveys are the primary method of rate setting for long-term services and social supports.

The second category of unlinked codes comprises rates for long-term services and social supports. In 2010, the Legislature amended statute to remove automatic rate adjustments for these services. Since then, the division's primary method of assessing rates for home- and community-based services has been to conduct in-depth cost surveys of current service providers.[6]

Cost surveys capture detailed financial information from providers as a basis for determining rates necessary to cover costs. These surveys, while useful at determining direct-care and overhead costs, have several limitations if used as the sole basis of setting rates.

Cost surveys only capture services actually delivered. If some participants do not have access to services because Medicaid rates are too low, the cost survey will underestimate necessary rates. For example, in our report, *Residential Care*, we found that some high-need Medicaid participants could not be discharged from hospitals because no assisted living facility would accept them at the Medicaid rate. A cost survey capturing the costs of assisted living facilities would not capture the cost of serving these participants.

Cost surveys take a long time to complete and longer to impact rates given the state budgeting process. By the time the rates are adjusted, the data used to inform the survey may be well over a year old.

6. Home- and community-based services are meant to keep participants at home rather than institutional care.

The more providers rely on Medicaid payment, the less useful a cost survey is in setting rates. For these services, cost surveys alone are insufficient to set appropriate rates. The survey will reflect the historic rate paid by the division and leave out important factors such as policy changes, changes in cost drivers, or changes to the composition of membership or utilization.

Cost surveys may be more narrow than the scope of services offered by the provider. For example, the same provider may offer both residential habilitation and vocational rehabilitation services using the same staff that share many of the same expenses. The division conducted two separate cost surveys and proposed adjustments for the two services at different times. The result was an increase in administrative burden for the providers and a disincentive to offer the service paid at the lower rate.

Legislative line-item approval results in longer delays for rate adjustments.

The minimum delay between the division calculating a new rate and the rate going into effect is 13 months.

Statute requires the Legislature to approve changes to the fee schedule by approving a line item in the budget request for the Department of Health and Welfare. The result is a minimum delay of 13 months between the division calculating the impact of rate adjustments, developing the budget request for a new rate, and that rate going into effect.[7]

The 13-month delay assumes that the division completes calculations for rate increases by the end of May or early June. Calculations completed after June mean that providers will wait additional time so that increases can be incorporated into the budget process. A 13-month delay also assumes that no unforeseen problems arise and that increases are approved by the Legislature and the Governor's office.

The most recent rate increase for children's developmental disability services is a useful example of how long rate adjustments can take. A timeline this adjustment is shown in exhibit 2. This exhibit illustrates the decision points for a standard rate setting process and how unforeseen problems can prolong the time between the cost study and the final rate adjustment implementation.

7. The Division of Medicaid has a June deadline within the Department of Health and Welfare to submit proposed line-item increases. State agencies must submit their budgets by September 1. If approved by the Legislature, payment rate increases generally go into effect July 1 of the following year.

Exhibit 2

The most recent rate adjustment for children's developmental disability services was scheduled to take 2 years to implement, but a calculation error delayed the final adjustment by 1 year.

2016	
August	Division announced it would initiate a cost survey to adjust rates previously set in 2011
December	Division began collecting 2016 provider cost data
2017	
July	Division reviewed cost survey data, calculated the budget impact of proposed rate adjustment, and submitted a budget request for a $2 million
December	Governor recommended no rate adjustment
2018	
January	Providers lobbied the Legislature for rate increase
March	$1.6 million for rate increases approved by Legislature and signed into law by Governor
May	Calculation error identified; provisional rate created to stay within appropriation
July	Provisional rate increase of 5.65% took effect
September	2nd Budget request submitted; $6 million across 3 decision units for the correct cost adjusted for inflation to July 2019
December	Governor recommended no rate adjustment
2019	
April	$6 million for rate increases approved by Legislature and signed into law by Governor
July	Final rate increase implemented

Source: Myers and Stauffer, *Children's Developmental Disability Cost Survey Results*, Department of Health and Welfare (January 15, 2019); Legislative fiscal reports from fiscal years 2017—2020.

Rate setting should be guided by well-operationalized measures of access, quality, economy, and efficiency.

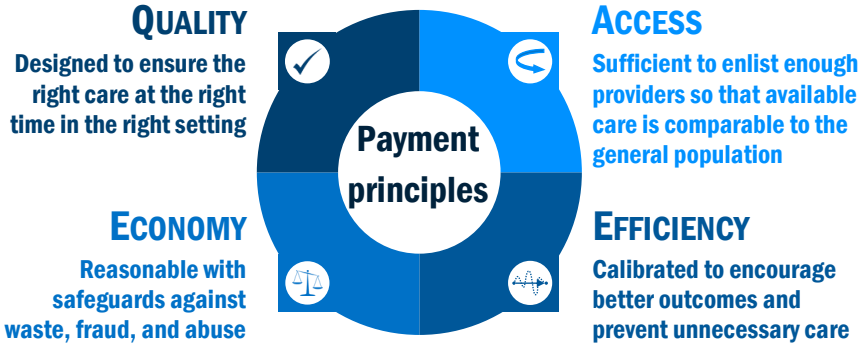
State and federal law set criteria for Medicaid payment policy. Policy should allow participants to access services in their geographic area comparable to the general population, while promoting efficiency, quality, and economy and protecting against payment for unnecessary care (see exhibit 3).

These broad concepts need to be translated into specific, measurable outcomes that capture Idaho's priorities and are appropriate for the type of service and participants' needs. Ideally, the division would proactively monitor these metrics.

A proactive monitoring system has three benefits. First, it would allow Medicaid to prioritize rate adjustments in response to emerging system-wide access or quality problems. Measures of access, quality, and efficiency allow Medicaid to tie payments to providers that perform well on the metrics. Finally, a proactive monitoring system would allow the state to better measure the success of rate adjustments and policy changes.

Exhibit 3

Principles of Medicaid payment policy are set in state and federal law.



Source: Idaho Code § 56-251 states "The legislature believes that the state of Idaho must strive to balance efforts to contain Medicaid costs, improve program quality and improve access to services." These measures are also codified in Section 1902(a)(30(a) of the federal Social Security Act.

The division prioritizes rate adjustments based on complaints and costs instead of well-operationalized measures.

The division monitors program quality for long-term care and social services through

- compliance reviews with providers,
- case reviews with individual participants, and
- payment policy reviews intended to prevent fraud or waste and boost program integrity.

The division monitors access through tracking complaints. Participants, or providers on their behalf, may submit formal complaints. The division also receives informal complaints from providers and lawmakers.

The division's performance measures primarily focus on problem avoidance, not desired outcomes.

These activities may well be effective at the case level, but these are not sufficient at the system level. The division's measures primarily focus on problem avoidance. Without measures that track desired outcomes, it is difficult to determine the severity or frequency of a problem raised by a complaint.

For example, if a provider submits a complaint about low payment rates affecting service delivery, the division does not have the tools to distinguish between: (1) a problem isolated to the individual provider, (2) regional dynamics leading to a problem in one area of the state, and (3) a rate that is too low throughout the state. Also, providers are less likely to complain when rates are set too high.

For participants, submitting a complaint is not always straightforward. And problems may be under reported. Problems experienced by participants with less access to technology or who cannot overcome the informational and bureaucratic hurdles to submit complaints will not be heard and thus not measured.

The division cannot measure the severity of reported problems. Are participants being mildly inconvenienced by waiting a little longer for services? Or, are the difficulties providers experience preventing or delaying treatment and causing health declines for participants?

The division does not have a robust and collaborative system to monitor access, quality, economy, and efficiency.

Medicaid is a joint federal-state program. While federal law sets many standards, Idaho has significant discretion in deciding who should receive benefits, what goals we want those benefits to achieve, and how (and how much) to invest in achieving those goals. The broad concepts of access, quality, economy, and efficiency need to be translated into specific and measurable objectives based on the priorities that Idaho wants to drive its Medicaid program.

We recommend that the Division of Medicaid explicitly identify program goals, develop performance indicators, and embed these measures in the rate-setting process.

This recommendation is easier said than done. The division cannot do this in isolation. Statute lays out broad policy goals for certain populations (see exhibit 4). Translating those broad goals into measurable objectives will require input from policymakers, participants, and providers. The division must work iteratively with stakeholders to evaluate how well the indicators accurately reflect the success of the program. This process will likely be a multi-year effort. Appendix d has examples of efforts in other states.

With these measures, the division would be able to evaluate the outcomes of rate adjustments and other policy changes. Lawmakers and taxpayers would be able to know their return on investment.

The measures should allow the division to track positive outcomes as well as problems. Compliance and problem avoidance are measures of good governance, not measures of progress toward intended outcomes.

The measures should be developed collaboratively with health care communities and program participants. Stakeholders should have a clear channel of communication with the appropriate contact within the division.

Exhibit 4

Idaho Code sets policy goals for Medicaid services delivered to different population groups.

Target population	Broad policy goal
Children in low-income households Working-age adults	Achieve and maintain wellness Emphasize prevention, good health choices Strengthen employer-based health insurance
Persons with disabilities or special health needs	Finance and deliver cost-effective, individualized care Emphasize individual choice, independence, and community and family-centered care
Dual-eligible participants in Medicare and Medicaid	Deliver cost-effective individualized care Emphasize preventive care Improve integration and coordination

Source: Idaho Code§ 56-251

Rate reviews should be regular, public, and incorporate stakeholder input.

Cost studies are one tool available to the division to find an appropriate rate. Rates can be derived from comparable payment made by other state programs, by private insurance companies in Idaho, or, if available, market prices.

We recommend the division's rate review include the following six elements:[8]

- a schedule that prioritizes and groups codes developed in conjunction with stakeholders
- a review of the payment method to ensure that the method adequately balances provider administrative burden with the division's informational needs
- structured and predictable times and forums for public and provider input
- explicit and publicly available information about the choices and assumptions made in developing the rate
- a consideration of whether services would be enhanced by allowing regional-, credential-, or population-specific rates
- a consideration of whether interim changes between major reviews is justified, and what the adjustment method should be

A periodic review of all rates, even those not requiring a cost study, would protect against unmeasured problems and reveal rates set too high. Reviewing each rate, rather than simply making across-the-board adjustments, is necessary because different industries have different cost drivers. Getting feedback even on rates tied to Medicare would be valuable. Medicare may have additional modifiers to codes, such as for rural providers or the rental of durable medical equipment. Identical billing codes may not always imply identical services.

8. This list is compiled from our review of other states. For examples, please see appendix D.

Questions for Providers Regarding Payment Methodology

The following list of questions for providers was developed by Myers and Stauffer when working with MaineCare to evaluate the state's rate-setting system.

Is the payment methodology transparent and easily understandable?

Does the methodology create opportunities for efficiency and economy?

Does the methodology create administrative burdens in terms of billing and oversight?

Does the methodology reflect how you deliver services? For example, do you typically provide a bundle of services but have to bill separately for each one? Does the methodology require that you bill for minutes of services, when an hour or greater might be more appropriate?

Does the payment methodology create the right incentives for:

- quality of care
- access to care
- primary and preventive care
- integration of care
- care coordination
- how members use services
- avoidance of abuse and fraud

In looking at the current payment methodology for the services you provide, do you believe that you/your services are treated equitably in comparison to other provider groups? Consider how fee schedules are determined, how they are updated, administrative burdens, incentives for quality and access, etc. Are all/most providers within your service area treated equitably?

Is the methodology consistent with value-based purchasing? Value-based purchasing is an approach that rewards value (quality of health care in comparison to cost), not volume (as fee-for-service does). Is it consistent with any other value-based purchasing approaches that you have in place through other payers with whom you contract?

Are there administrative requirements (e.g., coding, billing, reimbursement) placed on providers related to the methodology that make it burdensome for you?

Source: Myers and Stauffer, *Discussion Guide for MaineCare Rate System Reform*, (2020) retrieved from https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Rate-System-Evaluation-Discussion-Questions-Stakeholder-Meetings-09252020.pdf

3 Stewardship and management

Medicaid replaced state and local programs in Idaho that were aimed at serving the elderly, individuals with disabilities, and other vulnerable populations. Now, Medicaid is the primary funder of services and supports for these populations.

To some providers and for some services, Medicaid is just another insurance company. The Division of Medicaid's efforts are aimed at ensuring that enough providers are enrolled to meet demand and that services are appropriate. These providers—typically traditional medical providers—are part of an ecosystem of professional standards, accreditation, regulation, and consumer choice that minimize the role of the division's oversight. As one of many payers, the division's payment policies do not decide the fate of these providers.

However, other providers and services rely almost entirely on Medicaid funding. By covering these services, the state has made Medicaid a market maker; a key player in the ecosystem. These providers and services have the least oversight from elsewhere and serve individuals least capable of self-advocacy. The state has a special obligation to be a good steward of this ecosystem.

Medicaid is one of the state's most complex programs. The program's need for active, dynamic management has been a common thread since the program's beginning.

> These persistent problems demonstrate that they are the result of the division's failure to exercise proper contract monitoring practices, . . . understand the consequences of transitioning between different brokers and how their business practices impact participants, and be accountable to policymakers. The division should incorporate lessons learned from our 2016 report, Design of the Idaho Behavioral Health Plan.
>
> — Office of Performance Evaluations' management letter to Director Jeppesen, 2019

> We found a widespread lack of understanding of the department's choices leading up to managed care within the department, the Legislature, and the community. . . . More communication with stakeholders could prevent confusion about the objective and likely impacts of the change. . . . The department or any agency engaging in a complex program that primarily relies on contracting should make sure it has the skillset and expertise appropriate for the task.
>
> — Office of Performance Evaluations, *Design of the Idaho Behavioral Health Plan*, 2016

> Most of these issues could have been avoided if more pilot testing had occurred before the system went live and if better quality assurance measures were included in the Department of Health and Welfare's contract.
>
> — Office of Performance Evaluations, *Delays in Medicaid Claims Processing*, 2011

> The staff recommends that the Medical Services Administration must provide dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as Medicaid is to be soundly administered.
>
> — *Medicare and Medicaid: Hearings Before the Committee on Finance*, 91st Cong. 186 (1970)

Good rate setting first requires good benefit design and oversight.

The goal of Medicaid payment policy is to ensure that participants have access to quality care subject to economy and efficiency with safeguards against unnecessary utilization.

Achieving this goal requires more than setting an appropriate rate of payment. Goal attainment requires good benefit design which includes the following elements:[9]

- designing the scope of benefits to match participants' needs
- connecting participants with appropriate services
- monitoring the quality of services
- attracting and retaining high-quality providers through sufficient payment rates
- refining provider enrollment and payment policies to improve oversight and reduce administrative burden
- auditing records to prevent waste, fraud, and abuse

Problems with access, quality, economy, or efficiency may arise from a deficiency or imbalance with any one of these elements.

9. Medicaid and CHIP Payment and Access Commission, Chapter 2: Addressing Growth in Medicaid Spending: State Options (June 2016).

An effective review will require management capacity that the division lacks.

A systematic review of provider rates will require the Division of Medicaid to (1) credibly commit to a review schedule, (2) strategically and effectively engage with stakeholders, and (3) clearly communicate.

Management capacity requires sufficient time and resources to employ available ability, knowledge, and skill.

Management capacity requires not just knowledge, skill, and ability, but also the time and resources. Our previous reports have described a pattern of poor communication, strategic planning, and change management at the division. Our document review and interviews showed this pattern has persisted. We believe the division's management deficiencies come not from a lack of competence, but from asking too much from too few people.

The division's management deficiencies come from asking too much from too few people.

We found the division practiced good management when we reviewed documents from the division's planning and recent transition to value-based payment methods for hospitals and nursing homes. The division made strategic decisions, used contracted subject-matter experts, and engaged with stakeholders. As a result, stakeholders described a high regard for the division's work in the transition to value-based payment. Stakeholders spoke highly of the skill and ability of people at the division.

Credible commitment to strategic initiatives

A systematic review of rates is a long-term project that requires dedicated resources and careful project management. Stakeholders should be able to make decisions based on the review schedule (*e.g.* make business plans, target communication efforts, and make more informed budget decisions).

Division administration has struggled committing to long-term projects, including prior rate review schedules. A lack of faith in the division's commitments undermines some of the benefit of a systemic and systematic review.

Based on our previous reports and interviews with key staff, we identified three root causes of the division's struggles.

Lawsuits, crises, and external pressure drive the division's strategic priorities rather than a strong internal vision. The division prioritizes projects reactively rather than proactively. Lawsuits and changing expectations from the federal government drove some priorities. Other priorities came from management attempting to be responsive to powerful stakeholders.

New projects are prioritized over the successful implementation of existing projects. Rather than turning down new projects or asking for sufficient resources, staff must take on new responsibilities at the expense of existing ones. Staff reported that this worked at some points in the past when the division had excess capacity, but that such capacity had long been exhausted.

Project planning is rushed to prioritize responsiveness, leading to underdeveloped plans and no way to assess success. As we have written in previous reports, a successful implementation of strategic initiatives requires careful planning.

Strategic engagement with stakeholders

A systematic review of rates would communicate *when* rates will be reviewed and *who* stakeholders can go to with concerns about rates.

Stakeholders are frequently directed to the department's labyrinthine and inaccessible website.

Staff were frustrated by having to solicit feedback without the ability to incorporate any feedback.

Advocates, participants, and providers we interviewed shared frustration about their attempts to give feedback to or to solve a problem with the division. Stakeholders reported being passed from one staff member to another, never reaching resolution. Or worse, staff would direct the stakeholders to the department's labyrinthine and inaccessible website. Similarly, staff expressed frustration at having to solicit feedback from stakeholders when internal constraints prevented the incorporation of any feedback.

The division's problems with stakeholder engagement are exemplified by the state's Medical Care Advisory Committee. This committee, composed of practitioners, participants, lawmakers, and advocates, exists to provide advice and professional judgment to benefit the Medicaid program and to communicate the division's strategic initiatives to stakeholders. According to federal guidance, "The annual report of the Advisory Committee should be an important public document, looked forward to by

the public, by the professions, and by the consumers."[10] Idaho administrative rule requires an annual report of the committee.[11]

Though required in rule, the committee produces no such report. While the committee meets regularly, the last publicly posted record of meeting minutes is from 2018. Federal guidance suggests that the Medicaid program commit a full-time staff member to the committee. Medicaid staff should train and onboard members, keep members continuously informed about the program, and present material and decisions in ways that use the committee's time "to the greatest possible advantage."[12] By contrast, members of the Idaho committee (and of its subcommittee in statute, the Personal Assistance Oversight Committee), felt that the committee was never anyone's primary responsibility. One committee member described the meetings as "jargon and update filled" rather than opportunities for meaningful work.

The Medical Care Advisory Committee does not produce an annual report as required by rule.

Committee members felt that assisting the committee was never anyone's primary responsibility.

Clear and credible communication

Rate reviews should produce a report with clearly stated recommendations, prioritized rate adjustments, and strategies for implementing rate changes. Producing the report would allow stakeholders and lawmakers to understand, challenge, and ultimately find credible the outcome of the review.

If the division's communication with its governing committees, filled with subject-matter experts, is considered jargon-filled, its communication with lawmakers and the public is often incomprehensible. Stakeholders we interviewed reported that staff rarely "know how to talk to real people" and are in "serious need of plain language training." The concern about clear communication is not limited to the division; with a few exceptions, stakeholders found that communications from the department increased their confusion and furthered mistrust.

The division's communication with lawmakers and the public is often seen as incomprehensible.

The department is aware of this perception of its communication. The most recent strategic plan notes that "Idahoans often find that our external communication materials use government jargon and are not written in language appropriate for the target audience." A rate review will only be useful if its outputs are clear and contain the appropriate level of information for policymakers.

10. Medical Services Administration, Department of Health Education and Welfare, Medical Assistance Manual, (1971): 7
11. IDAPA 16.03.09.013
12. Medical Services Administration at 5.

The Legislature should not expect dynamic management from a division with fewer staff, more than twice the benefit spending, and nearly twice the enrollment of 2009.

In fiscal year 2009 the Legislature authorized 290 positions for the Division of Medicaid, then called the Medical Assistance Services Division. In fiscal year 2022, the Legislature authorized 77 fewer positions. Sixty of those positions were transferred to create the Division of Licensing and Certification. Adjusting for the transferred employees, the division has 17 fewer positions than it did in 2009.

At the same time, Medicaid enrollment increased more than 75 percent and benefit spending has increased by almost 125 percent.[13]

The division asked for 12 new positions in 2019, which would have brought staffing close to 2009 levels. The Governor recommended four of those positions, but none of them were approved by the Legislature.

The division's staffing levels compare poorly to similar state insurance-like agencies.

	Medicaid	State Insurance Fund
Annual benefits	$3.7 billion (fiscal year 2022)	$240 million (fiscal year 2020)
Staff	213	258

Source: Staff and pay from Transparent Idaho; Medicaid benefits refer to trustee-and-benefit payments. State Insurance Fund benefits refer to workers' compensation premiums from the 2020 annual statement.

13. Spending adjusted to July 2020 levels using the CPI-U-RS.

Since 2009, the division has increasingly focused on providing benefits through managed care. Under managed care, the state plays a different role: one of oversight and strategic management rather than conducting day-to-day operations. Conceptually, this could allow the division to employ fewer staff while expanding its operational capabilities.

However, the decrease in staff did not come with a strategic change in the division's operations. Instead, staff move from crisis to crisis while less urgent work is neglected. For example, when a lawsuit necessitated more quality control staff for the Bureau of Developmental Disability Services, the division reclassified existing positions to meet the urgent need. The division did not ask for any additional resources to replace the reclassified positions, impacting the work of other units at the division.

Staff move from crisis to crisis while less urgent work is neglected.

Division of Medicaid leadership often lack administrative staff, leaving some of the division's highest-paid and most specialized employees responsible for tasks such as taking meeting minutes. Our reports on the Idaho Behavioral Health Plan and on Non-Emergency Medical Transportation show that the division attempted to transform benefit delivery without strategically assessing staff needs.

Our previous reports showed that the division attempted to transform benefit delivery without assessing staff needs.

More than a decade of our reports, spanning several division administrators, suggest that the division's management problems will not be fixed without the Legislature investing in sufficient capacity at the division to successfully implement what they have been asked to do. We recognize that Medicaid is a program with many conflicting priorities, from cost containment to provider network expansion. Whatever the priorities, the division does not have the capacity to implement all of the things they are asked to do well.

The division does not have the capacity to implement the number of things they are asked to do well.

The Legislature should decide how much Medicaid administration it wishes to control or delegate and invest accordingly.

The current distribution of rate-setting authority is based on the budget crises around 2010 and 2011. After more than a decade, it has become clear that neither the division nor the Legislature have the authority and information to manage rate setting. As the timeline of the rate adjustment for children's developmental disability services in the last chapter shows (exhibit 2), the Legislature has full authority over rates but gets information filtered through the division, through the department, and through the Governor's office. This makes it particularly difficult to assess the consequences of rate-setting decisions on participants and providers.

Lawmakers do not trust what administration tells them and administration fears asking for what it needs.

The distance between information and authority is exacerbated by an environment where lawmakers do not trust what Medicaid administration tells them and Medicaid administration fears asking for what it needs. The study request for this evaluation illustrates this mistrust stating that "the Medicaid Division is continually challenged in its ability to provide a systemic and systematic plan for provider payment review. . . . Although the department is currently planning its own review and methodology development, a concurrent study by [OPE] could ultimately assist the Department." Our interviews revealed a high degree of reluctance within the division to ask for additional resources based on prior lack of support.

The Legislature has a range of options if it wants to close the distance between its authority and information.

At the very least, the Legislature should ask for an annual report containing the following information:

- rates that will be reviewed in the upcoming fiscal year
- the results of the most recent rate reviews, including the cost of fully implementing the findings of the review
- the reasons for the deviation between the division's funding request and the full cost of implementing the findings of the rate review
- A description of the state's return on investment by reporting the status of access, quality, efficiency, and economy measures

The Legislature may wish to consider adjusting the delegated authority to the division such as allowing the division to make mid-year adjustments to rates in response to observed needs and avoid the 13-month lag between the division's request and the rate change. The division may include information about these decisions in the annual report.

The Legislature may wish to receive more communication about aspects of Medicaid administration beyond rate reviews. This could include a Medicaid-specific strategic plan identifying program-specific goals, risks, and updates. This would allow Medicaid to prioritize and manage long-term initiatives. It could also help provide information on trends to help the Legislature contextualize stakeholder feedback.

As part of both the rate review and strategic planning, the Legislature may wish to consider creating a committee or work group that includes legislative appointees or legislators to guide the process and provide Medicaid clear feedback about legislative priorities. The Legislature should be sensitive that any new reporting will likely require increased capacity at the division.

The division should identify its most urgent staffing needs and include a request in the budget request for the 2023 legislative session.

The division has recently changed executive leadership; the transition represents an excellent opportunity for the administrator to assess and report to the Legislature about the division's staffing needs. Based on our review, increased capacity is likely needed in at least the following areas:

- administrative support for the Medical Care Advisory Committee
- stakeholder management to further cultivate relationships with the medical community, advocacy groups, and participants
- data analysis to create a pipeline of useful management information through mining existing sources and reporting performance measures

We recommend that the division identify its key management needs and submit a budget request for the 2023 legislative session that addresses those needs. This request should be made in consideration of the six best practices for rate setting and the proactive monitoring system discussed in the previous chapter.


A
Request for evaluation

HOME ADDRESS
5370 ELMORE ROAD
FRUITLAND, IDAHO 83619
(208) 250-6744

DISTRICT 9

STATE CAPITOL
P.O. BOX 83720
BOISE, IDAHO 83720-0081
alee@senate.idaho.gov
(208) 332-1325

Idaho State Senate

SENATOR ABBY LEE

March 8, 2021

Senator Mark Harris, Co-Chair, Joint Legislative Oversight Committee
Representative Illana Rubel, Co-Chair, Joint Legislative Oversight Committee

Dear Co-Chairs,

The Idaho Department of Health & Welfare, Division of Medicaid, has conducted provider payment studies over the past few years. Although some of these rate reviews have been completed, the Medicaid Division is continually challenged in its ability to provide a systemic and systemic plan for provider payment review. The following chart was provided last year by the Medicaid Division as an outline of available and planned studies:

Proposed Rate Review

Provider Type	Last Rate Adjustment	Rate/ Methodology Review
Medicaid Only Providers (Yearly)	2013	Methodology Creation SFY2020
Rural Services	2007	Methodology Creation SFY2020
Intermediate Care Facilities (ICF)	7/1/2019	Methodology Review in SFY2021
Nursing Facilities (NF)	7/1/2019	Methodology Review in SFY2021
Hospitals	10/1/2019	Methodology Review in SFY2021
Private Duty Nursing (PDN)	7/1/2019	Rate Review SFY2021
Home Delivered Meals	2006	Rate Review SFY2021
Developmental Disability Agencies (DDA - Adult)	7/1/2013	Cost Survey in SFY2021
Targeted Service Coordination Agency (TSC)	4/1/2013	Cost Survey in SFY2022
Personal Assistance Agencies (PAA)	1/1/2018	Cost Survey in SFY2023
Residential Habilitation Agency (ResHab)	7/1/2018	Cost Survey in SFY2023

(graphic emailed by Idaho Medicaid Division Director Matt Wimmer to Senator Abby Lee, Feb. 2020)

Although the Department is currently planning its own review and methodology development, a concurrent study by the Office of Performance & Evaluation could ultimately assist the Department in developing a sustainable rubric and evaluation method to consistently evaluate, predict, and more adequately plan for provider rate reviews. Therefore, I request JLOC approve an OPE study to examine how the Division of Medicaid conducts provider rate reviews, which may include the following:

- Review of existing provider payment studies within the Division of Medicaid
- Evaluation of the current/ proposed methodology the Division of Medicaid uses/will use to review provider payment adjustments
- Recommendations on best practices and/or methodology for provider payment review

Developing a systemic and systematic method, as well as an annual schedule for provider rate reviews, would also be beneficial in assisting the Joint Finance Legislative Committee in budgeting for provider rate adjustments. Thank you for your consideration of this request.

Sincerely,

Senator Abby Lee

B Evaluation scope

Guided by the findings of past evaluations conducted by our office and others, we will evaluate the management process used by the Division of Medicaid to set provider reimbursement rates and develop budget requests. We will assess how well the division's management practices promote the primary Medicaid goals found in Idaho Code § 56-251 and federal law of providing access to quality services in a way that is economical, efficient, and avoids unnecessary costs. These management practices include the following:

- administration of the provider rate-setting process
- stakeholder communication
- budget forecasting and monitoring
- performance monitoring regarding service access, quality, efficiency, and economy

Methodology

C

Report approach

After receiving the study request, we interviewed the study requester, lawmakers suggested by the requester, and legislative staff. We also reviewed legislative documents, including statute and committee minutes. With this background information, we developed a list of documents to request from the Division of Medicaid. We also asked for access to their intranet and for any documents that the division believed to be relevant to answering the questions posed in the study request.

It became clear that the root cause behind the concerns leading to this study request were related to concerns about the strategic management of the Medicaid program and the communication between the program and the Legislature. As such, our approach shifted from the technical development of rates to higher-level management concerns.

Evaluation history

Our choice to focus on higher-level management concerns was driven, in part, by the recent history of studies from our office concerning the Division of Medicaid. The complexity of the Medicaid program carries a risk that a focus on the details will detract from the fundamental problems facing the program.

Evaluations of the Division of Medicaid

Since 2011, we have conducted three evaluations of programs under the Division of Medicaid.

2019: *Non-Emergency Medical Transportation*

We sent the department a management letter concerning the division's inability to give us the information necessary to complete our report on non-emergency medical transportation. Nevertheless, we suggested the problems with the program came from poor contract management, poor analysis and decision making, and an inappropriately passive approach to managing the service.

2016: *Design of the Idaho Behavioral Health Plan*

The Idaho Behavioral Health Plan was Idaho's first major managed care contract, covering outpatient behavioral health services. We found that the department poorly communicated the goals of the plan, failed to plan for resources needed to develop and manage a contract, and did not plan or document risks or decision points.

2011: *Delays in Medicaid Claims Processing*

The Division of Medicaid had transitioned to a new Medicaid Management Information System, which among other things automated payments to providers. The transition was a disaster, as providers were paid incorrectly or not at all for services rendered. We found that unclear contract requirements, a lack of system readiness, and inadequate end-user participation created the challenges of the transition.

Evaluations involving the Division of Medicaid

In addition to evaluations of programs managed by the Division of Medicaid, we have conducted evaluations of state policies and programs which include Medicaid as a major player. The following evaluations included recommendations that involved the Division of Medicaid.

2020: *State's Response to Alzheimer's Disease and Related Dementias*

The Division of Medicaid is a major funder of personal care services for Idahoans with dementia and their families. We found that Idaho's formula for reimbursing long-term care providers likely failed to account for the time needed to care for someone with cognitive decline, reiterating a finding from our earlier evaluation, *Residential Care*.

2018: *Residential Care*

The Division of Medicaid is the primary, non-private payer for residential care for both children and adults.

We found that Idaho was sending children on Medicaid out of state for treatment even when other states were sending their children on Medicaid to Idaho. Providers tried to get approval to accept Idaho Medicaid but never received clear direction from either the Division of Medicaid or the Division of Licensing and Certification.

When compared to neighboring states, we also found that Idaho had fewer residential care options, paid a lower rate, and did not adjust rates based on participant needs for Medicaid participants with dementia. In addition, we found Idaho was not participating in a home-and-community-based state option that would carry a higher federal match.

Staff and stakeholder interviews

We conducted a series of semi-structured interviews with policy makers, program staff, provider representatives, participants, and advocates. Early interviews focused on problem identification, understanding the program, and understanding the context of the study. Later interviews focused on the development of criteria for the Medicaid program and an assessment of the program's condition. The following questions were asked of the provider associations and stakeholder groups:

- How well does the current rate-setting process help promote the goals of the Medicaid program (e.g. improve access to quality care, promote efficient services, and avoid unnecessary costs)?
- How well does the division communicate with providers?
- How well does the rate-setting process allow providers to make plans or adjust business practices so that serving Medicaid patients is sustainable?
- What would you want the Legislature to understand about the Medicaid rate-setting process?

Overall, we interviewed 51 individuals, including 8 individuals with leadership positions at the Department of Health and Welfare, 26 individuals representing 8 providers or provider associations, and 9 individuals representing Medicaid participants or their advocates. We also spoke with individuals from the National Association of Legislative Fiscal Officers and the National Association of Medicaid Directors.

Rate setting

Criteria development

We reviewed federal and state statutory language governing rate setting and documents pertaining to Idaho's legislative history involving Medicaid.

Our stakeholder interviews helped to clarify stakeholder expectations about Medicaid rate reviews and to develop criteria. The interviews also highlighted how the current rate-review process deviates from these criteria.

In addition to the interviews, we reviewed federal and industry guidance as well as comparisons with other states. Appendix D offers additional details on these resources.

Condition assessment

The Division of Medicaid provided us with many documents relating to the calculation and review of provider rates. We also used descriptions of rate-setting methodologies contained in Idaho's waiver applications for services for individuals with disabilities or for the elderly needing long-term care.

Budget documents

To understand and evaluate the process by which a rate review becomes a formal line item in the department's budget request, the department gave us the following:

- the division's budget calendar, which includes milestone dates for items to be submitted to the division administrator, department director, Governor's office, and Legislative services.
- the division's line-item requests at various points in budget request development

- spreadsheets outlining the calculations of the budget impact of changes to provider rates.
- monthly budget reports that included current, projected, and historical information on spending back to 2011 (These reports are used by the division in their monthly meetings with the Division of Financial Management and Legislative Services)

These documents demonstrated the methods the division used to propose rates and to estimate the fiscal impact of rate changes. These also demonstrated the various steps at which requests from operational staff could be filtered out at the levels of the administrator and department director.

The spreadsheets outlining the fiscal impact of updating Idaho's rates to the most recent Medicare rates included a list of all billing codes paid in fiscal year 2019, by amount billed, amount paid, units billed, and units paid. We used this data to identify the number of codes and the amount spent that was tied to Medicare codes.

Cost surveys

The division gave us cost surveys conducted by Myers and Stauffer on behalf of the division. These cost surveys covered 1) children's developmental disability services, 2) community supportive employment services, 3) personal care agencies, 4) residential assisted living facilities, and 5) supported living services – residential habilitation (ResHab). The division also gave us the past several wage surveys (also known as WAHR surveys) of various provider types and other documentation used to determine rates.

These cost surveys contained documentation of assumptions and decisions made in calculating rates and a timeline of activities for each survey.

Procedures and trainings

The division gave us the procedures used to update various rates and training material used to onboard new employees involved in rate setting.

The entirety of these documents convinced us that the division had adequate technical expertise to conduct the rate-review process and was conducting the process in a way that significantly aligned with our management recommendations in *Design of the Idaho Behavioral Health Plan*.

Monitoring

The criteria for Medicaid payment policy are clearly embedded in state and federal law. Payment should allow participants access to care equivalent to others in the same geographic area; payment should promote quality and ensure economy and efficiency while discouraging unnecessary care.

We discussed monitoring in our stakeholder interviews. We also reviewed federal guidance and the efforts of other states to establish criteria for a proactive monitoring system and to assess Idaho's current monitoring practices.

Federal and industry guidance

CMS has developed two 'core sets' of measures that are currently voluntary for states to report. One set is specific to children, one to adults. Starting 2024, the child core set and adult core set measures relating to behavioral health will be mandatory for states to report. The child core set includes measures such immunization statuses for children and adults, timeliness of prenatal care, and percentage of eligible children who received preventive dental services. The adult core set includes screening for various cancers, controlling high blood pressure, and follow-up after emergency department visit for mental illness or alcohol and other drug abuse.

According to CMS's 2021 state profile for Idaho, Idaho reported 15 percent of child quality measures and 33.3 percent of adult quality measures. Idaho is in the bottom quarter of states of measures reported for both data sets.

We considered the federal measures as a minimum standard for Idaho. These measures tend to focus on areas of Medicaid most similar to traditional health insurance, thus excluding social supports provided to individuals with disabilities or to the elderly.

Documentation from the division

Once we established the centrality of monitoring to the rate-review process, we requested additional information from the division regarding its monitoring efforts. We also collected other publicly available documents.

The documentation was notable for its lack of measures that would help guide a rate review and help the division evaluate the impact of rate adjustments or other management initiatives.

Monitoring documents

For the adult developmental disability program, performance measures reported on their dashboard included measures such as:

- the number of providers meeting certification standards,
- the number of providers that received a quality review on time,
- the number of providers that meet state training requirements,
- the number of service plans reviewed that document various service plan requirements,
- the number of plans reviewed that indicate services were delivered consistent with the approved plans, and
- the number of participants who received an annual wellness evaluation.

These measures tracked at or near 100 percent, with the exception of training requirements. These measures are not sensitive to change and do not provide a meaningful description of actual performance.

Long-term care monitoring included many of the same measures, plus measures focused on internal operations such as the number of assessments completed. The team also monitored complaints and critical incidents. The team had also started to ask questions regarding participant satisfaction as part of their annual assessment process.

While the measures included in the monitoring documents are helpful, they are largely focused on avoiding problems rather than assessing whether the program is achieving the program's intended goals.

Idaho's Healthy Connections Value Care program had some valuable system-level measures: ER utilization, proportion of clients with a wellness visit, and the proportion of children whose blood levels were tested for lead. These measures were available at the clinic level, region level, and statewide.

The monitoring documents, along with our interviews with stakeholders, led us to conclude that Idaho does not have a proactive system of monitoring access, quality, economy, and efficiency, though Healthy Connections Value Care program represents a good start. The monitoring of the state's managed care contracts, as well as the external quality control reviews, suggests that the division has outsourced goals for access, quality, and efficiency to contractors while focusing solely on compliance and total cost.

Management and communication

Our previous reports raised concerns about the division's ability to commit to and successfully operationalize, a long-term project like a rate-review process.

In 2020 and 2021, the division initiated two major transitions in payment policy. First, the division tied supplemental payments to nursing homes to measures of quality. Second, the division transitioned the payment method for inpatient hospitalization from a cost-based method to a method based on the severity of the diagnosis.

We requested documents from the division relating to these two transitions. The division provided 1) a consultant report outlining significant choices relating to hospital payment, 2) meeting minutes for the series of meetings with stakeholders for both changes, 3) for the nursing home transition, a record of options to be discussed with stakeholders and the rationale for the chosen option, and 4) records showing an interactive and data-driven approach to the hospital payment transition.

These documents showed a marked improvement over the records we reviewed for the decisions regarding the Idaho Behavioral Health Plan or the nonemergency medical transportation broker. However, still lacking was a plan to monitor and protect against unintended consequences. Stakeholders worried that, once the new payment methods went into effect, the division would focus its resources elsewhere rather than ensure the transitions had their intended outcomes. Combined with staff and stakeholder frustration about the poor execution of other significant initiatives, we concluded that, while the division had the capability to manage a project well, it did not have the capacity to manage the number of projects it was undertaking.

Additional resources

D

This appendix contains model programs in other states relating to our recommendations as well as guidance from other authorities. The sources are organized by their primary topic. However, rate setting, monitoring, management, and communication are deeply entwined processes. For example, resources that discuss successful rate setting also contain valuable insight about monitoring and communication.

Rate setting

Federal and industry guidance

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees state Medicaid programs. CMS has a variety of trainings and material about rate reviews, primarily focused on Home and Community Based Services (HCBS). We used these trainings to develop criteria for Idaho's rate-setting process.

Engaging Stakeholders in the Rate Setting Process, CMS, 2019

> This training reviews the federal requirements relating to rate setting for 1915(c) Waivers, i.e., those for HCBS. In the waiver application, states must clearly define the methods used to determine payment rates. A key criterion for evaluating the methods is how stakeholder input was considered.
>
> The training reviews the types of rate setting in HCBS, common rate-setting components—wages, productivity assumptions, employer related costs, administrative overhead, program support costs, and staffing ratios—and methods for setting rates.
>
> CMS describes a five-step approach for effective stakeholder engagement, the first of which includes "a defined workplan

for rate methodology updates that includes an approach for continuous stakeholder engagement" and that "States should develop this approach early in the rate… setting process and communicate engagement opportunities with stakeholders."

The second step is to identify stakeholders. The third is to identify key topics to address with stakeholders (which is different by service and stakeholder group) and includes the state "provide summaries of the public information and stakeholder input organized by topics and themes." The fourth is to identify ways to engage with stakeholders, such as through town halls, steering committees, surveys, and the website. The final step is to gather and incorporate feedback where appropriate.

Cost Factors and Rate Assumptions Template, CMS, 2017

This document is a training about how to use a template for developing rates for HCBS where direct-care wages are the primary component. The template allows rates to be adjusted based on acuity, qualifications, staffing ratios, geography, and other components. The template allows for the rate development to include differentials in wage inflation, productivity (e.g., due to driving time), employee benefits, paid time off and training, administrative overhead, program support, and any other cost factors.

Ensuring Rate Sufficiency: Rate Review and Revision Strategies, CMS, 2016

This training came about after the *Armstrong v. Exceptional Child* case bolstered CMS' responsibility for overseeing rates. The document details five main approaches to ensure that rates are sufficient to ensure access, quality, economy, and efficiency.

Approach 1: Evaluate feedback from individuals, families, independent case managers, advocacy groups, and providers about the adequacy of direct service providers. Include a review of fair hearings, grievances, and complaints related to lack of providers and complement this information with individual and provider surveys.

Approach 2: Benchmark rates to those for comparable services. Compare rates with similar services paid for by the state, rates for similar services by public or private payers, or rates for similar services from bordering states and states

with demographically similar populations.

Approach 3: Review evidence related to performance measures that assess whether participants receive the type, scope, amount, duration, and frequency of services specified in their service plans.

Approach 4: Measure changes in provider capacity. Collect information on staff turnover and retention from providers, review data on provider enrollment, disenrollment, units of service or individuals served per provider, etc. Particularly useful to compare this information before and after a rate change.

Approach 5: Benchmark rate assumptions to available data, such as wage data from state run facilities or from the Bureau of Labor Statistics. The adjustments would include non-direct costs such as described in the *Cost Factors and Rate Assumptions Template*.

The rate review can result in 1) rate adjustments, based on budgetary, legislative, or programmatic changes; 2) a rate rebase, where the state maintains the same rate-setting methods but adjusts the individual inputs (e.g., increasing the weight of employee benefits based on market changes); 3) bundled rate recalibration, where the state recalculates the mix of services that make up a bundled rate; or 4) rate methodology redesign, where the state completely reevaluates the current rate-setting method.

Other relevant documents we reviewed from CMS included the following:

Pay-for-Performance Rate Methodologies in a HCBS FFS Environment, CMS, 2017

Trends in Rate Methodologies for High-Cost, High-Volume Taxonomies, CMS, 2017

Tiered Rates: Trends in Acuity-Based and Geography-Based Rate Variation, CMS, 2017

Documentation of Rate Setting Methodology, CMS, 2016

Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers, CMS, 2016

Medicaid and CHIP Payment and Access Commission

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides analysis and makes recommendations to Congress, the Department of Health and Human Services, and states. MACPAC publishes a wealth of data and documents. We used MACPAC's page on overview of provider payment and delivery systems for background research and to understand terminology. We used MACPAC's work to understand various aspects of Medicaid payment policy and to understand the relationship between payment policy and access, quality, economy, and efficiency.

The Medicaid Fee-for-Service Provider Payment Process, MACPAC, 2018

> This fact sheet walks through the process by which providers are paid under a fee-for-service arrangement with Medicaid. The process starts with authorization and moves through service definition, claim submission, adjudication, payment, and post-payment review. MACPAC reviews each of these steps in detail, outlining options available to states at each stage.

Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy, MACPAC, 2018

> This fact sheet outlines the three major methods that states use to pay for inpatient hospitalization: diagnosis-related groups, where hospitals are paid a fixed amount per discharge; per-diem, where hospitals are paid based on the number of days a patient is in the hospital; and cost-based, where hospitals are paid based on reported costs. MACPAC walks through the options available to the states under each method and identifies payment policy issues.

A Framework for Evaluating Medicaid Provider Payment Policy, MACPAC, 2015

> This chapter helped cement the importance of having well-developed measures of access, quality, economy, and efficiency driving Medicaid's payment policy, including the rate-review process. The document also drove home the necessity of well-developed performance monitoring for value -based payment strategies.
>
> In this chapter from MACPAC's report to Congress, MACPAC outlined a framework for evaluating payment policy. Using

this framework, MACPAC hoped "to pinpoint the payment approaches that best address efficiency and economy while promoting access to quality services and appropriate utilization."

"Economy, quality, and access are discrete but related outcomes of payment policies. It is necessary, therefore, to consider the relationships of the principles to each other rather than attempt to evaluate them individually. Efficiency is not only a component of quality, economy and access; it is also the overarching goal of payment policy."

MACPAC emphasized that Medicaid is a dominant payer for obstetrics, pediatrics, behavioral health, and long-term services and supports, as well as a critical source of revenue for public hospitals, community health centers, and children's hospitals. "After years of focusing primarily on prices, state Medicaid programs increasingly are adopting more sophisticated purchasing strategies emphasizing value. Payment policy can be a powerful lever to contain costs and improve access to and quality of care."

The chapter discusses the relationship between payment policy and each of the goals of access, quality, economy, and efficiency, discussing what is known about the relationship and the data limitations for evaluating the relationship. The chapter also identifies secondary goals for payment policy, including administrative simplicity, program integrity and transparency, budget predictability, alignment with other payers, and fairness.

Other documents reviewed for background information on rate setting include the following:

Nursing Facility Fee-for-Service Payment Policy, MACPAC, 2019

Medicaid Physician Fee-for-Service Payment Policy, MACPAC, 2017

Federal Requirements and State Options: Provider Payment, MACPAC, 2017

Other state rate reviews

In our conversations with subject-matter experts, we were referred to two states that were engaged in a systematic rate-review process during our fieldwork.

Colorado

The Colorado rate-review process was enacted in statute in June 2015. Information regarding the rate-review process is on the state Medicaid program's website. Colorado's process contained several elements that informed our development of criteria for Idaho's review.

A formal rate review advisory committee comprised of professionals and Medicaid recipients appointed by majority and minority leadership in both legislative chambers. The committee: 1) sets a 5-year review cycle based on state Department and public input, 2) assesses whether rates need to be reviewed out of cycle, 3) recommends to the joint budget committee areas for process improvement, and 4) takes public comment on reports issued as part of the rate-review process.

Extensive publicly available documentation of meetings, including minutes, handouts, written stakeholder comments, and webinar recordings.

A published 5-year review schedule that includes 1) a prioritization and grouping of rates for review with specified dates of review, 2) rates excluded from the rate setting process and an explanation for their exclusion.

Published annual reports summarizing 1) high level information about who is covered by Medicaid, 2) service-specific analysis of utilization, access, and quality, 3) comparisons of service rates with available benchmarks, 4) advisory committee and department recommendations for rate changes with estimates of fiscal impact, and 5) recommendations for changes in payment methodologies.

Maine

In January 2020, Maine's Medicaid program announced a process to review all of the program's fee-for-service rates over the next two years. Maine hired a national consultant to administer the process. Documentation about the process is on the Medicaid program's website. Unlike Idaho, Maine did not

systematically tie its rates to a percentage of Medicare rates. Maine's review included the following elements to inform Idaho's rate-review process.

Publicly available spreadsheets of every procedure code for each category of services. These spreadsheets include 1) the current rate for the procedure code, 2) the number of units and amount paid for the procedure code the previous calendar year, 3) the comparable Medicare rate, where available, 4) comparable rates paid by the Medicaid programs in Connecticut, Montana, New Hampshire, North Carolina, and Vermont, and 5) the 25th, 50th, and 75th percentile rates paid by Maine's commercial payers. We used these spreadsheets for some initial comparisons with Idaho's fee schedule.

Two phases of structured stakeholder engagement meetings. The first phase included a discussion of payment methodology, apart from rate. That discussion guide is here. After the first phase, stakeholders were given a summary of the consultant's findings of comparable rates along with the service-specific spreadsheets. The second phase of stakeholder engagement meetings focused on feedback on whether the rates selected for comparison were appropriate. Recordings of all stakeholder meetings were posted online.

Interim and final reports included 1) recommendations for methodology and rate changes, 2) recommendations for a future adjustment schedule, and 3) a priority order for the recommendations. The department also published budget estimates for the proposed reforms.

Monitoring

In addition to the core sets discussed in appendix C, the following resources may be valuable in developing a robust and collaborative system of monitoring quality, access, efficiency, and economy.

Federal and industry guidance

Examining Access to Care in Medicaid and CHIP, MACPAC, 2011.

> In this chapter in MACPAC's report to Congress, MACPAC lays out a framework to monitor access to care. MACPAC argues that "a monitoring system could help policymakers understand whether they are purchasing value in the form of efficient and high-quality care for their enrollees."
>
> The chapter argues that access has three main elements: 1) enrollee characteristics and needs, which differ from the general population; 2) provider availability to meet the needs of the enrollees; and 3) actual utilization of services. The chapter suggests a number of potential measures focused both on provider availability and participant experience.

State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level, prepared for MACPAC by Dybdal, Hartman, and Spencer, 2015

> This report highlights the centrality of monitoring to value-based payment methods.
>
> The report reviews payment reforms in seven states, distilling lessons for other states. "In most advanced payment models… provider financial gains are dependent on achieving a certain level of performance on a set of quality measures. As such, measuring cost, utilization, and quality goes hand in hand with reforming payment structures. State Medicaid programs involved in reforming payments to providers have had to make significant investments in the data infrastructure and data analytic resources necessary to track these metrics at the provider level."

Other documents reviewed for background information on rate setting include the following:

Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States, prepared for MACPAC by Teisl, Blewett, and Sonier, 2014

Quality Measurement for Home and Community Based Services (HCBS) and Behavioral Health in Medicaid, prepared for MACPAC by Hartman and Lukanen, 2016.

Other states

Legislative intent language and subsequent evaluation

Texas

In addition to regular performance measures, when the Texas legislature has a particular concern or question about the performance of certain services paid for by Medicaid, the legislature includes intent language. In 2017, the Texas General Appropriations Act included a request for an evaluation of client outcomes for substance use disorder treatment services provided by Medicaid (see section 29 on page II-54 of the bill). The Texas Health and Human Services Division published the evaluation in November 2017.

The Texas Medicaid website has a landing page for reports and presentations. This page makes it easy to find reports of their advisory committees, evaluations, rate modernization progress reports, and quarterly reports. The reports can be filtered by year, the legislative session, or the bill number that contained the intent language that sponsored the report.

Multi-year planning efforts to coordinate program, stakeholder, and division activities

Alabama

The Integrated Care Network (ICN) Quality Assurance Committee was created to identify objective outcomes and quality measures for nursing facility services, home-based and community-based support services, and any other such long-term health and medical care services the agency requires to be provided by an ICN.

The committee set up a multi-year project to establish quality measures that included timelines for benchmarking data, integrating stakeholder input, and establishing formal quality measures.

Colorado

Health First Colorado (Colorado's Medicaid program) released a 2021 evaluation and effectiveness review for assessing and improving the quality of managed care services. The program created a multi-year plan for how it would conduct the assessments needed to set performance measures and identify cost drivers. They reported their progress back to the legislature and made reports publicly available and easy to access.

The evaluation also reports on performance measures for goals such as:

- cost control
- member health
- customer service to participants, care providers and partners
- health equity

The program has a Legislator Resource Center that includes monthly newsletters, reports on performance measures, and county-specific facts.

Medicaid dashboard

Florida

Florida's Agency for Health Care Administration has developed a quality initiatives dashboard that reports performance metrics by state Medicaid region and other demographic data. Performance measures are reported for the following categories:

- potentially preventable emergency room visits
- potentially preventable admissions
- potentially preventable readmissions
- primary C-section
- neonatal Abstinence Syndrome
- preterm births

Stakeholder surveys

Connecticut

Connecticut tracks Medicaid participants' experience of care through standardized surveys. Survey items cover topics such as:

- access to needed care,
- getting care quickly,
- provider communication, and
- customer service.

Results are published in an overview of health quality and cost trends.

Responses to the evaluation

I appreciate the direction this report gives the department to further this work and improve upon the rate setting process.

—Brad Little, Governor

The Medicaid program in Idaho has evolved significantly and the complexity is a constant; having the appropriate staffing in place would allow the Medicaid Division to not only more effectively manage the day-to-day operations of the program but also to be more responsive to the provider and participant community.

—David Jeppesen, Director
Department of Health and Welfare

BRAD LITTLE
GOVERNOR

March 16, 2022

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Via Email: rmohan@ope.idaho.gov

Dear Director Mohan:

Thank you for your office's report on the state's Medicaid rate setting system. The report recognizes the difficult balance the state faces in managing a lean Medicaid budget while fairly reimbursing Medicaid providers and ensuring there is adequate access to quality Medicaid providers for clients.

The Department of Health and Welfare has started the process for an improved rate review process that will include stakeholders, include new factors and be sound fiscal policy. I appreciate the direction this report gives the department to further this work and improve upon the rate setting process.

Sincerely,

Brad Little
Governor

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

OFFICE OF THE DIRECTOR
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5500
FAX 208-334-6558

March 15, 2022

Office of Performance Evaluations
Attn: Rakesh Mohan
954 W. Jefferson St. Suite 202
Boise, Idaho 83702

Dear Director Mohan,

I want to thank you and your staff for the time and effort spent on your office's report of the Medicaid Rate Setting. As acknowledged in the report, Medicaid is an incredibly complex program and your review and report summarizes well the challenges and opportunities to evolve the rate review process, improve communication and best respond to the needs and sustainability of the Idaho Medicaid provider network.

- Establishing a strong provider network through which Medicaid participants can receive medically necessary services is a core element to effective and compliant Medicaid program administration. We appreciate the recommendations and agree there is significant opportunity to improve establishing and gathering data around measures of access, quality, economy, and efficiency within the program. We also acknowledge opportunities for improved stakeholder engagement and communication around these measures, inputs, and data analysis. Data analytics, network adequacy monitoring, and enhanced stakeholder relations are top priorities for the Division of Medicaid and this report outlines key recommendations and suggestions to move this work forward.
- This report outlines well the challenges the Medicaid Division faces with current resource availability. The Division is staffed with incredibly competent, dedicated, and innovative individuals who choose this work in public service because they are committed to the purpose and mission. Our staff seek to create a strong, sustainable program that best serves some of Idaho's most vulnerable citizens. The Medicaid program in Idaho has evolved significantly and the complexity is a constant; having the appropriate staffing in place would allow the Medicaid Division to not only more effectively manage the day-to- day operations of the program but also to be more responsive to the provider and participant community. We appreciate the acknowledgement of the staffing challenges and recommendation to evaluate staffing needs.

- Proactive and clear communication with all Medicaid stakeholders and state policy makers is a priority for the Medicaid Division and we agree there is opportunity for improvement. We stand ready to work with the Legislature towards improved communication and collaboration and intend to work with our stakeholder groups to identify better methods of information sharing and gathering of feedback.

The Division of Medicaid has worked this past year towards enhancements to our rate review process to include new factors and information as part of the review and to have a more comprehensive approach. While we believe we have made some improvements to this process, we know we still have work to do. This report has supported our understanding of some of our areas of deficiency and illuminated opportunities around communication and information sharing.

The Medicaid provider rate review processes and the supporting information we provide to policy makers is one of the most critical pieces of work we do to ensure a healthy provider network for Medicaid participants. We look forward to continued collaboration with the Legislature around this work and how to best respond to the needs of Idaho's Medicaid providers and participants.

Thank you again for your time and attention to improving the Medicaid rate setting process.

Sincerely,

Dave Jeppesen
Director

Office of Performance Evaluations

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Idaho Legislature